TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Texas Health of Cleburne

Respondent Name
Texas Mutual Insurance

MFDR Tracking Number
M4-17-2922-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
June 2, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Per the TDI /DWC fee schedule this account qualifies for an Outlier payment… The correct allowable due is $5,642.04 less their previous payment of $3,383.67, which leaves an outstanding balance of $2,258.37."

Amount in Dispute: $2,258.37

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The following is the carrier's statement with respect to this dispute of 8/15/2016. The requester billed $28,903.43; Texas Mutual paid $3,383.67. The requester believes it is entitled to an additional $2,258.37. …No additional payment is due."

Response Submitted By: Texas Mutual

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 15, 2016	Outpatient Hospital Services	$2,258.37	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403 sets out the reimbursement guidelines for outpatient hospital services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
    - P12 – Workers' compensation jurisdictional fee schedule adjustment
    - 236 – This billing code is not compatible with another billing code provided on the same day

according to NCCI or Workers compensation state regulations/fee schedule requirements

- 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated
- 370 – This hospital outpatient allowance was calculated according to the APC rate plus a markup
- 435 – Per NCCI edits, the value of this procedure is included in the value of the comprehensive procedure
- 616 – This code has a status Q APC indicator and is packaged into other APC codes that have been identified by CMS
- 618 – The value of this procedure is packaged into the payment of other services performed on the same date of service
- 767 – Paid per O/P fg at 200% implants not applicable or separate reimbursement (with cert) not requested per Rule 134.403(G).
- W3 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly
- 350 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal
- 724 – No additional payment after a reconsideration or services

Issues

1. Is the requirement for outlier payment met?
2. Is additional payment due?

Findings

1. The requestor states in their position statement, "…this account qualifies for an Outlier payment which is as follows: Outlier: $22,202.25 Total Allowable Charges x .234 Cost to Chg Ratio = $5,195.33 Hospital's Cost."

   28 Texas Administrative Code 134.403 (d) states in pertinent part,

   > For coding, billing, reporting, and reimbursement of health care covered in this section, Texas workers' compensation system participants shall apply Medicare payment policies in effect on the date a service is provided

   Review of the 2016 OPPS Final Rule Facility Specific Impact file at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS finds the Outpatient Cost-to-Charge Ratio for Provider Number 450148 to be 0.160 not .234 as stated by the requestor. Therefore, the requestor's position statement is not supported.

   The Medicare payment policy found in the Medicare claims processing manual, Chapter 4, at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c04.pdf states,

   > *The current outlier payment is determined by:*
   >
   > *• Calculating the cost related to an OPPS line-item service, including a pro rata portion of the total cost of packaged services on the claim and adding payment for any device with pass-through status to payment for the associated procedure, by multiplying the total charges for OPPS services by each hospital's overall CCR (see §10.11.8 of this chapter); and*
   >
   > ***• Determining whether the total cost for a service exceeds 1.75 times the OPPS payment and separately exceeds the fixed-dollar threshold determined each year;***

Review of the submitted medical bill finds the codes classifications are as follows:

- Procedure code J7030 has status indicator N. No APC assignment.
- Procedure code 36415 has status indicator Q4. No APC assignment.

- Procedure code 82803 has status indicator Q4. No APC assignment.
- Procedure code G0479 has status indicator Q4. No APC assignment.
- Procedure code 85025 has status indicator Q4. No APC assignment.
- Procedure code 85027 has status indicator Q4. No APC assignment.
- Procedure code 85610 has status indicator Q4. No APC assignment.
- Procedure code 85730 has status indicator Q4. No APC assignment.
- Procedure code 81001 has status indicator Q4. No APC assignment.
- Procedure code 71010 has status indicator Q3.This is assigned APC 5521.
- Procedure code 72170 has status indicator Q1. No APC assignment.
- Procedure code 72125 has status indicator Q3. This is assigned to composite APC 8006.
- Procedure code 74177 has status indicator Q3. This is assigned to composite APC 8006.
- Procedure code 76376 has status indicator N. No APC assignment.
- Procedure code 70450 has status indicator Q3. This is assigned to composite APC 8006.
- Procedure code 70486 has status indicator Q3. This is assigned to composite APC 8006.
- Procedure code 71260 has status indicator Q3. This is assigned to composite APC 8006.
- Procedure code 73700 has status indicator Q3. This is assigned to composite APC 8006.
- Procedure code 31500 has status indicator T. This is assigned APC 5161.
- Procedure code 96361 has status indicator S. This is assigned APC 5691.
- Procedure code 96374 has status indicator S. This is assigned APC 5693.
- Procedure code 99285 has status indicator J2. This is assigned APC 5025.
- Procedure code J0330 has status indicator N. No APC assignment.
- Procedure code 93005 has status indicator Q1. No APC assignment.

Based on the APC classifications shown above the outlier calculation is found below.

APC Payment Amount	APC Total Cost	Allocated percentage	Allocated portion	Line item cost	APC payment x 1.75	APC Payment plus $3,250 (fixed dollar threshold)	Outlier payment requirement met?
8006 $493.91	$2,995.08	38.19%	$234.56	$3,229.64	$493.91 x 1.75 = $864.34	$493.91 + $3,250 = $3,743.91	No
5521 $60.80	$76.00	4.70%	$28.87	$104.87	$60.80 x 1.75 = $106.40	$60.80 + $3,250 = 3,310.80	No
5161 $129.29	119.24	10.00%	$61.40	$180.64	$129.29 x 1.75 = $226.26	$129.29 + $3,250 =$3,379.29	No
5691 $30.87	12	2.36%	$14.66	$26.66	$30.87 x 1.75 = $54.02	$30.87 + $3,250 = $3,280.87	No
5693 $92.40	37.60	7.14%	$43.88	$81.48	$92.40 x 1.75 = $161.70	$92.40 + 3,250 = $3,342.40	No
5025 $486.04	312.36	37.58%	$230.82	$543.18	$486.04 x 1.75 = $850.57	$486.04 + 3,250 = $3,736.04	No

2. As shown above the Medicare payment policy for outlier payments was not met. No additional payment is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031, the division hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

		June 28, 2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.